(2) **Short stay outlier days** shall mean the patient's entire length of stay in those cases where the patient's length of stay is less than the short stay outlier trimpoint provided in section 86-1.63 and any patient discharged from a hospital on the day of admission including patients assigned to a transfer DRG and excluding patients defined as transfers and normal newborn cases and normal deliveries.

(3) **High-cost outlier costs for payment purposes** shall mean 100 percent (or 100 percent multiplied by the reduction percentage calculated pursuant to section 86-1.54(f)(3)(iv)) of those additional costs determined pursuant to section 86-1.55(c) that are in excess of the greater of the hospital case based rate of payment for the DRG multiplied by two or the hospital's average case based rate of payment multiplied by six subsequent to the elimination of all prospective adjustments which reflect a retroactive impact of an adjustment in accordance with section 86-1.61(l) of this Subpart, provided such payment exceeds the payment for such case determined pursuant to section 86-1.55(b) of this Subpart for a long stay outlier. High cost outlier payments for transferred patients other than those assigned to transfer DRG's shall be made only to the hospital discharging the patient as defined in section 86-1.50(i).

(h) Alternate Level of Care Services (ALC) shall be services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available.

(i) Discharges. For purposes of payment under the case based payment system, an inpatient shall be defined as discharged when the patient's admission to the facility occurred on or after January 1, 1988, and:

(1) the patient is released from the facility to a non-acute care setting; or

(2) the patient dies in the facility; or

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(3) the patient is transferred to a facility or unit that is exempt from the case based payment system except when the patient is a newborn transferred to an exempt hospital for neonatal services. Such infants shall be classified as transfer patients; or

(4) it is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

(j) Transfers. (1) A transfer patient shall be defined for purposes of transfer per diem payments as a patient who is not discharged as defined in subdivision (i) of this section, who is not transferred among two or more divisions of merged or consolidated facilities, who is not assigned to a DRG specifically identified as a DRG for transferred patients only, and who meets one of the following conditions:

(i) is transferred from an acute care facility reimbursed under the DRG case based payment system to another acute care facility reimbursed under this system; [or]

(ii) is transferred to an out of state acute care facility[.]; or

(iii) is a neonate who is being transferred to an exempt hospital for neonatal services.

(2) Transfers shall include but not be limited to transfers between more than two acute care facilities, and transfers from those hospitals excluded from the DRG case based payment system because of participation in an approved Medicaid cost control program or demonstration, to a hospital reimbursed pursuant to the DRG case based payment system.

(k) Exempt hospitals and units shall be those hospitals and units that are paid per diem rates of payment pursuant to the provisions of section 86-1.57 of this Subpart, rather than per discharge case based rates of payment.

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Attachment 4.19-A
Part I

(1) The wage equalization factor (WEF) is the mechanism to equalize hospital salary and fringe benefit costs to account for the differences in the price of labor among hospitals and groups of hospitals.

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(m) The power equalization factor (PEF) is a mechanism to equalize hospital utility costs to account for the differences in the price of power, electrical and gas costs among hospitals and groups of hospitals.

(n) Payors that reimburse hospitals on an expense incurred basis.*

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86-1.51
Attachment 4.19-A
Part I

Section 86-1.51. Payor rates of payment. (a) The same DRG case based rates of payment effective for the year in which the inpatient is discharged, adjusted for non-covered services, shall be paid for all inpatient hospital services provided to patients admitted on or after January 1, 1988 and shall be used by the following payors:

(1) State government agencies;

(b)(1) Hospitals shall be reimbursed for days of acute care delivered to patients in 1988 who were admitted in 1987 at the 1987 operating per diem rate established for the hospital, trended to 1988, and the 1987 allowances which hospitals received pursuant to section 86-1.11 of this Subpart, plus the capital per diem component of their final 1987 rate, based upon reconciliations performed on a cumulative basis on or about March 31, 1988 and December 31, 1988.

(2) For all other discharges the hospital shall receive the payment rate developed for the year in which the inpatient is discharged.

(c) (1) reserved

(2) reserved

(d) reserved

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(e) reserved

(f) reserved

(g) reserved

(h) reserved
(i) reserved

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86-1.52 Payment components. (a) DRG case-based rates of payment per discharge. Payments to hospitals that are not exempt hospitals or units for inpatient acute care services shall include:

(1) a DRG specific operating cost component calculated in accordance with section 86-1.53 of this Subpart, which includes:

(i) hospital-specific indirect costs associated with graduate medical education;

(ii) hospital-specific costs associated with hospital medical malpractice insurance, ambulance services, organ acquisition, schools of nursing, radiology and/or laboratory technology, hospital based physicians and the direct costs associated with graduate medical education determined pursuant to the provisions of section 86-1.54(g) of this Subpart and

(iii) special additional inpatient operating costs added to the 1988 cost bases of all hospitals licensed under Article 28 of the Public Health Law that are reimbursed according to the provisions of this Subpart.

(a) An amount equal to $130 million shall be distributed to all eligible hospitals through additions to the 1988 reimbursable costs used to calculate the case based payment rates for rate year 1988 pursuant to subdivisions (a) and (b) of section 86-1.54 of this Subpart and such additions shall be trended to subsequent rate years.
Such amount shall be allocated as follows:

(1) five hundred dollars per bed shall be allocated to the costs of each general hospital based on the total number of inpatient beds for which the hospital is certified as of January 1, 1988;

(2) a factor of 1/4 percent of a general hospital's trended reimbursable inpatient operating cost as defined in section 86-1.54 of this Subpart, shall be allocated to costs of general hospitals for technology advances;

(3) a factor of 1/4 percent of a general hospital's trended reimbursable inpatient operating cost as defined in section 86-1.54 of this Subpart shall be allocated to the costs of general hospitals for increased activities related to quality assurance and patient discharge planning; and

(4) the balance of the one hundred and thirty million dollars after deducting the dollar value of the allocation specified in subclauses (1), (2) and (3) above shall be allocated to costs of general hospitals based on the ratio of each general hospital's 1985 costs incurred in excess of the trend factor between 1981 and 1985 in the following discrete areas, summed, to the total sum of such cost over trend of all general hospitals applied to such balance: malpractice insurance costs, infectious and other waste disposal costs, water charges, direct medical education expenses, working capital[,] interest costs of hospitals that qualified for distributions pursuant to section 86-1.36 of this Subpart, costs of distinct psychiatric units excluded from the case based payment, and ambulance costs. For the purpose of this sub-

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clause, 1985 cost incurred in excess of trend factor between 1981 and 1985 shall be calculated for each such discrete area based on a general hospital's inpatient operating costs,

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